IDAHO CRIME VICTIMS COMPENSATION PROGRAM

Initial Treatment Plan

☐ **CHIROPRACTIC CARE** ☐ **MASSAGE THERAPY** ☐ _____

CV#: _____ Patient's Name: _____
Parent/Guardian: _____ Tax I.D. #: _____
Treatment Provider Name: _____
Credentials: _____

Are you a provider under the following programs?
☐ Medicaid ☐ Medicare ☐ TriCare Other _____
☐ Blue Cross ☐ Indian Health Services ☐ Blue Shield

Indicate what sources of payment are available to this patient: _____
Date treatment began: _____ Number of sessions to date: _____

1. **Please describe the presenting symptoms or conditions for which the patient is seeking treatment.**

2. **Does the patient have a history of any conditions that required similar treatment in the past?**
☐ Yes ☐ No If so, please indicate the type of treatment, approximate dates and reasons for treatment.

3. **Please provide a brief description of the crime as related to you, including a description of the injury sustained and the source of the information (i.e. patient, parent or other).**

4. **Please describe any pre-existing conditions that may affect treatment and to what extent these conditions may have been exacerbated by the crime.**

5. **Indicate percentage of treatment you are providing that resulted from non-crime related injuries.**
_____ %

6. **Describe the symptoms or conditions you are treating that are a <u>direct</u> result of the crime.**

7. **Indicate percentage of treatment you are providing for conditions that are a direct result of the crime. (Percentages from #5 and #7 should equal 100%)** _____ %

8. **Estimated duration of treatment: from** _____ **to** _____

9. **Estimated cumulative cost of treatment: $** _____

10. **List below the treatment goals for this patient, give specific physical measures and projected dates to achieve each goal.**

Symptom/Condition	Treatment Goal	Method	Target Date

14. **I certify that the information provided in this treatment plan is true and accurate. I acknowledge that if the alleged offender is convicted, the Program will request the criminal court to order the alleged offender to pay restitution to reimburse the Program for expenses paid on behalf of the patient. I further understand that this document may be submitted as evidence and that I may be called to testify regarding the treatment outlined in this plan.**

Signature of Treatment Provider _____ Date _____

Title _____